Chapter 5

Civic Confidentiality and Psychoanalytic Confidentiality

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As historical studies show (e.g., Kerr, 1993; Lynn and Vaillant, 1998; Tomlinson, this volume), psychoanalysis did not actually start out as a notably confidential profession. This was probably not because psychoanalysts in Freud's day were somehow less aware or less scrupulous than, say, medical doctors. Of course, the fledgling profession sometimes got a little drunk on its novel status as a radical therapy; some of its pioneers, particularly Jung, were intoxicated by romantic fantasies of discovery and correspondingly ruthless, at least by the standards of today, in their use of clinical material for purposes of self-promotion. Nevertheless, most of the early analysts were medical doctors, and in all probability their ethical practice was roughly comparable to that of the medical profession as a whole. I suspect that it was precisely this sort of average, expectable practice that has until recently served to obscure consciousness of the very different function that confidentiality plays in a psychoanalytic context.

As psychoanalytic thinking has evolved toward fuller appreciation of the grip of unconscious mental life—extending the understanding of its role beyond intrapsychic conflict in the patient to the general and continuous interaction *between* the analyst and the patient—issues related to confidentiality have come to seem much more fundamental to the actual treatment process. We no longer think of confidentiality merely as an adjunct to clinical work derived from ethics; we are beginning to see its role as intrinsic to the therapeutic work itself, and to understand its meaning and effect as largely unconscious. This places psychoanalysis in a somewhat difficult position legally and ethically. It means that many of the standard methods of defining and handling confidentiality issues (such as the issuing of a Miranda-type warning at the beginning of treatment, the practice of obtaining informed consent when professional communication involving the patient is contemplated, and maintenance of a carefully documented, self-protective file of the treatment process) have turned out to be inapplicable or problematic in good analytic practice.

An important recent example of this was discussed by David Tuckett (2000) in an editorial of the *International Journal of Psychoanalysis*. He describes a new policy of the International Committee of Medical Journal Editors (ICMJE) making it mandatory to provide documentation of patient consent for publication and stipulating that "in all cases where patients' clinical records are disclosed in any way, there should be no attempt to disguise or misrepresent details." Of course, a ban on the use of disguise as a means of protecting the patient's anonymity would make ordinary psychoanalytic publishing virtually impossible. In the psychoanalytic context, as in no other, obtaining the patient's consent for disclosure is always a highly problematic and delicate matter. (I will discuss this in more detail later in this chapter.) Informed consent would become even more problematic under the ICMJE rules, which geometrically multiply the chances that the identity of the patient will be discovered.

In the psychoanalytic frame of reference, it is no longer possible to conceptualize confidentiality without object-relations theory and recent developments in the understanding of transference-countertranference dynamics. First, confidentiality obviously serves as a container for the analytic couple in multiple senses (Levin, 2001). On the societal level, it includes and provides the conscious and unconscious cultural underpinnings of social support for the analytic work. Where there is a strong tradition of individual liberty and privacy, in a society that understands the advantages of individual and professional autonomy and respects professional expertise and judgment, confidentiality in this externally containing sense is widely taken for granted—even when the legal infrastructure of confidentiality is undergoing serious erosion for administrative and bureaucratic reasons, as is the case in the Western world at present.

Confidentiality also serves as a container *within* the analytic process. It cushions the holding environment by helping to make the invitation to therapeutic regression unconsciously credible. It is also one of the mainstays of the analytic frame because it suggests and

defines most clearly the imaginary boundary separating social space from analytic space, and the conscious and unconscious suspension of the rules and norms of social relationships and conduct.

The Unconscious in Court

In the psychoanalytic frame of reference, then, confidentiality is no longer just a concept or an ethical principle; it has developed into a complex hybrid related to many aspects of the central technical problem of psychoanalysis: how to provide the optimal conditions for the emergence of the "psychic value [of patients' communications], that is, their capacity to carry the contents of unconscious thought" (Bollas and Sundelson, 1995). I borrow the phrase "capacity to carry the contents of unconscious thought" because it emphasizes the fact that unconscious thought is never disclosed or revealed, except perhaps in piecemeal form; it grafts itself silently onto the affective and verbal currents of conscious experience, only gradually forming a recognizable constellation in the mind of the analyst, if he or she is ready and waiting. It is difficult to impart the epistemological ambience of unconscious material, the sense that during the gradual course of analytic treatment the entire mental landscape can seem transformed, as significant sectors of the personality shift newly into view. In certain respects, this may also be true for the analyst, who must deliberately place his mind in a vulnerable position with respect to the unknown and the unconscious. Both analyst and analysand are exposed to the pressures and vicissitudes of an intense emotional relationship whose transformative potential may simply be lost without the interlocking nest of containing functions that confidentiality in the true sense is alone able to provide.

This is not a formulation of confidentiality that will often be heard in a court of law, and that is probably a good thing. The law remains rightly wary of references to the unconscious, which is not something that can be responsibly accessed through cross-examination. Democratic liberal theory wants and needs stable points of reference—in particular, the construct of individual social actors with rational interests, fathomable motives, and conscious intentions who are aware of what they are doing and why. Without this kind of grounding in a commonsense psychology of consciousness, the law risks becoming the handmaiden of political irrationality, unable to adjudicate a potentially infinite regress of ideological claims and counterclaims concerning any number of possible unconscious social and psychological causes of injustice and crime. The bench and the courtroom are not at all suitable for carrying the contents of unconscious thought, and any attempt to base legal reasoning on generalized theoretical speculation or "expert testimony" about unconscious motives, ideas, or processes would certainly put the reputation of the law at risk.[1]

Nevertheless, the need for confidentiality in psychotherapy, particularly psychoanalysis, does not seem to be in serious dispute anywhere in contemporary society. The debate is about how confidentiality should, or can, be legally protected, if at all: when does the principle obtain, and when does it not? There are many reasons why the law might be sympathetic to the psychotherapeutic profession, but the intellectual basis for it seems to rest on three main pillars:

- The pragmatic requirement that the professional gain access to vital information that would not otherwise be forthcoming;
- Constitutionally based respect for private life; and
- Trust, which the first two imply in different ways.

It seems reasonably safe to say that a public consensus has formed around the idea that psychotherapy requires the patient's "trust." This is part of the popular, bedrock understanding of psychotherapy and how it works. Judges and legislators can listen without embarrassment to arguments linking trust to "confidence," not only in the psychotherapist's commitment to maintain confidentiality but also (increasingly, in the present context of professional practice) in the therapist's ability to sustain this commitment under social and political pressure. This is such a basic argument that it has come to seem almost axiomatic. Unfortunately, the trust argument is sometimes stated in a misleading way, which anyone so inclined could easily demolish, leaving confidentiality with only the rather precarious right-to-privacy leg to stand on.

The dominant model of psychoanalytic psychotherapy in the public mind is that it is a treatment in which the patient chooses to "disclose" discrete bits of information that have been kept hidden

[1] Of course, this natural judicial wariness about building in an active approach to unconscious mental activity is precisely one of the reasons why the courts ought to avoid psychoanalytic case material as inherently unfathomable within a legal context of reasoning and investigation.

m others. (Our tendency to add dramatic spice inclines us to as-
ne that this hidden information is of special interest to the law.)
this view, the patient's "trust" in confidentiality is supposed to
courage the patient to "reveal" sensitive facts, things that the doc-
should know in the interests of good treatment. Most of the dis-
ssion about the legal status of confidentiality turns on this
nscious-information model of the therapeutic process. It is assumed
t the patient is hiding something, that he knows what it is, and
t he will make a conscious decision to go into therapy based on a
culation of the risk of disclosure to the therapist.

It is my impression that psychoanalysts have maintained a kind
discrete silence about the fact that this way of picturing the need
confidentiality is profoundly misleading, if not patently false. First,
ients very often do not consciously know what it is they are hid-
, if anything, let alone what they want to hide, so there is little
elihood here of a reasonable calculation of "risk." Ordinary human
ngs are normally ambivalent about whether they would prefer to
eal or conceal those aspects of themselves about which they are
are. One of the most difficult quandaries in psychoanalytic ethics
olves the not-uncommon situation in which patients, for uncon-
ous reasons, try to expose themselves in self-destructive ways,
ably by using the law to transform the analyst's notes (a focus of
ense fantasy activity) into an object of third party or self-scrutiny
e Furlong, 1998; Da Silva, this volume; Garvey, this volume).

A second but also very popular model of the psychotherapeutic
ocess does involve the notion of an exploration of the uncon-
ous. Unfortunately, it is too often conceptualized as the simple
ersion of the consciousness model of therapy, particularly under
influence of popular theories of "trauma" and "recovered memory."
amatic, Hitchcockian notions of what is involved in making the
conscious conscious have encouraged (not caused) an even more
sleading view of what it is that psychoanalysts want to be confi-
ntial about. As in the conscious-information model, the hidden
terial in Hitchcockian therapy is still specific, factual, and of great
erest to the law. Only it is "in the subconscious." The patient is not
are that this information exists, and the role of the therapist is first
uncover the information (perhaps with the aid of hypnosis) and
n to help the patient use the information to bring about justice,
ich will complete the process of healing.

The reality of psychoanalysis is of course very different from
se quaint fantasies. Psychoanalysts are neither accomplices to crime

nor detectives in search of it, and the "information" they work with is only superficially factual, usually ambiguous, and changes meaning with time. There is no doubt that when analysands begin treatment they frequently bring all sorts of specific "things" they want to "get off their chests." They are often feeling isolated from family, friends, and colleagues, sometimes because they have managed somehow to get themselves into a "jam"—secret lovers, hidden debts, questionable transactions that may come to light, or shameful impulses that are difficult to conceal from public view. Their conscious motive for coming into treatment may be to find someone they can talk to without risk of disclosure—someone who will keep the information secret, give advice, and magically relieve the sense of guilt. What is less well-known is that no matter how much a patient may "believe" in confidentiality, he is just as likely *not* to "disclose" such "secrets," if they exist, until much later in treatment. The fact is that willingness to "disclose" may have more to do with the patient's evolving perception of the analyst, regardless of the state of the law on confidentiality, or the patient's evolving perception of himself, as it develops in treatment. What might have seemed too embarrassing to discuss at the beginning of treatment becomes a year or two later an interesting curiosity to be explored with the analyst.

Patients do not necessarily begin therapy laden with secrets; and even when they do, it is surprising how infrequently they are concerned about confidentiality, or the risks of disclosure, in a conscious or calculated way. They usually just want to make sense of what they are feeling or not feeling, or to understand a strange mood that is haunting them for reasons they cannot quite grasp. Of course they do not wish to have the details of their private lives revealed to all and sundry. But it would never occur consciously to most patients that a competent analyst would violate the Hippocratic oath for no good reason. Even the reporting laws do not (yet) *consciously* inhibit so many patients because, after all, they believe they have nothing to hide and the analyst will have no reason to report!

The point is that whether or not the patient was thinking in terms of security of secrets at the beginning, the actual unfolding of the treatment will usually not have much to do with hot bits of "confidential" information. The latter generally play only a secondary or superficial role in the patient's suffering.

Indeed, there is the strong likelihood that in fact patients ordinarily do not trust their analysts anyway. They may say they do, but analytic patients will normally raise serious issues of trust as time in

the treatment goes on and frequently will betray a very deep-seated lack of trust of everyone, especially the analyst. Successful psychoanalytic treatments are frequently conducted in an atmosphere of suspicion and doubt, which only gradually dispels toward the end of treatment. So the argument that confidentiality is vital to psychotherapeutic treatment because it helps the patient to establish that "all-important" trust in the therapist is less than wholly convincing.

Does this mean that we have to abandon the argument that confidentiality is in a profound sense *constitutive* to the psychoanalytic relationship and process? On the contrary, it means that we have still to make a serious effort to substantiate this claim. In order to begin to do so, we need to distance ourselves somewhat from the standard arguments based on trust, effective as they may be for the moment in the courts. So long as we remain addicted to convenient arguments because they are palatable in the civic arena, we will never bother as a profession really to think through carefully the basis of the claims we are making in this area. Eventually, the flimsiness of the trust arguments will be exposed in legal argumentation or through the inevitably ambiguous results of research surveys. If psychoanalysis is not, at that juncture, prepared to advance a more sophisticated account, legal and public faith in confidentiality may be further undermined.

From a psychoanalytic point of view, trust is both supported and undermined in unconscious mental life and therefore deeply implicated in the transference. It is entirely possible, for example, that an analysand in Hungary after the 1956 Soviet invasion, when confidentiality was for all intents and purposes illegal, might consciously have trusted his analyst because he perceived him as someone willing to break the law to protect his patient. Unconsciously, however, such trust would probably have been fragile. To give a different example, the most scrupulously ethical New York analyst, who would go to jail to protect his analysand's confidentiality, might be experienced transferentially as a liar and a mercenary who would sell his patient down the Hudson River at the first opportunity. No amount of legal protection for confidentiality will convince this patient that he can trust his analyst, yet the analysis continues, and the patient somehow "trusts" his analyst to tolerate and understand his pathological distrust.

It is, I shall contend, absolutely true that this kind of trust in the face of distrust (and even in the face of hostile threats of the report-

ing laws and managed-care companies) is only possible in an atmosphere of strict confidentiality, but the confidentiality in question is not derived from laws and codes of ethics. It is confidentiality as a *professional ethos*, implied confidentiality, confidentiality as an emergent property of psychoanalytic culture. It is part of the procedural knowledge the patient acquires merely by living in a society where psychoanalysis still enjoys a certain measure of respect. The remarkable thing is that confidentiality in this very deep, preconscious sense is even implicit in the patient's willingness to test the analyst's neutrality, to challenge the reliability of the frame, for example, by provoking, mistreating, and even attacking the analyst. It is not just that the patient believes that the analyst will not do anything to discredit the patient in public or among his family and friends; he senses preconsciously that the analyst will even try to refrain from mobilizing those parts of himself that might react defensively to the patient.

This is a vital aspect of confidentiality in the actual doing of psychoanalytic work. What it amounts to in practice is a sense that the analyst develops, in large measure through profound internalization of the ethos of confidentiality, that he or she must try to avoid "blabbing" about the patient *in the session to the patient*. For example, suppose that the analyst has a superego reaction to the patient's unusual masturbation practice. Bowing to the pressure of his own superego, the analyst appeals in turn to the patient's superego to put a stop to this practice. This is a crude example of an often subtle unconscious process that is impossible for analysts not to fall into sometimes, a kind of distortion of the therapeutic alliance in which the therapist splits the patient into favored and unfavored parts. The temptation then becomes very strong to start "telling on" one side of the patient to the other. This would be "blabbing" about the patient in the session to the patient, and it is precisely where the ethic of confidentiality can sustain the deepest clinical work.

Though seemingly innocuous, blabbing to the patient about him involves an erosion of confidentiality at several levels. First, to put it crudely, within the analyst the superego has failed to keep the working ego's confidence. Second, inside the patient, who is struggling to understand himself, the freed-up parts that are beginning to do analytic work and to free associate must now contend with a reinforced thought police. Not only do the thought police have a new potential ally in the analyst, but also, and worse, the vital sense that experience

can be contained has been threatened.[2] Opportunities for internal recognition and integration may give way to more splitting and internal suppression.

The fact that an analytic patient can actually entertain such an impossibly demanding intimacy of his analyst is the stuff of confidentiality. It nourishes the psychological roots of minute, day-to-day technical judgments in analytic therapy. Though related to what we have usually been talking about when we try to make legal arguments for confidentiality, it is really something quite different.

The Very Idea of Confidentiality

These considerations bring us round to an important issue that has been largely overlooked in the current policy debates on confidentiality, namely, that the idea of confidentiality has emerged "internally" from the actualities of professional practice, not from the conceptual instantiation of the law. Law has not (and probably cannot) create confidentiality in any meaningful sense; it can only recognize it where it is already practiced by establishing what in common law is termed a "privilege." This is true even of lawyer-client privilege, which, though considered fundamental to any liberal legal system, does not actually derive from the law itself but from the practice of the law. Realistically speaking, then, we should not expect confidentiality to function well when it is refashioned as a deduction from first principles, or manufactured through the application of a general concept, such as privacy. Functional confidentiality is a kind of procedural knowledge, closer to the understanding that develops in an ongoing relationship, a commitment that asserts itself within the shared performance of a particular task, such as physician care, sacerdotal intercession, or legal advocacy. It is, in other words, the expression of a professional ethos, without which the performance of the task itself would lose all social credibility.

It follows naturally from this argument that confidentiality in a psychoanalytic context involves a unique confluence of cultural evolution (notions of individuality, privacy, and legal precedents for professional secrecy) with the particular, and only recently evolved,

[2]This is why when we do feel obliged to set conditions on the patient's behavior, for example with regard to serious suicide threats, we feel that we have lost an important dimension of the therapeutic space, though the patient has given us no choice.

conditions of psychoanalytic practice itself. In other words, confidentiality in the psychoanalytic context is not a self-evident thing that can be inferred from the state of the law, medical or psychiatric precedent, or some ideal definition of the relevant ethical principles. It is something that will have to be explained, and most of the explaining will have to be done by psychoanalysts, in a dialogic process with society.

Moreover, if it is true that confidentiality is the expression of a professional ethos, another very onerous consequence obtains: namely, that when the ethos is ailing, all the privacy laws in the world will not save confidentiality for that profession. What was (or might have become) confidentiality in the true sense for that profession will instead degenerate into an abstract concept, perhaps a "right." The profession may cling desperately to this "right," but its value will be entirely contingent on political and social fashions, to be weighed against all the other rights and duties mandated by the State.

Absolute Confidentiality

The idea of confidentiality arising in the practical context of a relationship as the expression of a professional ethos is a far cry from the mainstream of bioethical discourse, with its administrative functions of codifying, balancing, and applying abstract principles and universal rights in the massive and impersonal domains of funded research and "health-care delivery systems." The contemporary discourse on confidentiality has many points in its favor, but it has also fostered a misleading way of framing certain issues. A good example of the latter is the frequent use, on both sides of the debate, of the phrase "absolute confidentiality." From a point of view internal to psychoanalysis, the idea that confidentiality might ever be "absolute" makes little practical sense. Yet such a position is routinely attributed to those who resist the intrusions of the law on psychoanalytic practice: any attempt to defend the merits of independent professional judgment in situations where the law has intervened to compel disclosure is stigmatized as absolutism. This is a rhetorical gambit that distracts attention from the main object of concern—not the absolute, but confidentiality itself. As Christopher Bollas (2000) has suggested, what is really in dispute is whether there should be confidentiality at all or whether it should be "qualified" into practical nonexistence.

One of the basic assumptions fueling the controversy over the absolute is the notion that confidentiality is actually the patient's right as a citizen, that confidentiality should be conceived as an individual right in all circumstances---or only in certain circumstances, such as those of a woman alleging sexual assault. The inevitable corollary of this argument is that, like all rights, the right will have to be balanced against other rights, such as a defendant's right to a fair trial or the rights of children. Once the definition of confidentiality as a right has been conceded, there is no avoiding the balancing argument, and any attempt to resist this logic will be interpreted as another example of the absurd doctrine of absolute confidentiality, i.e., as holding confidentiality above the law. When confidentiality is a right, rather than a professional practice, then it must *always* (the only alternative is *never*) be balanced, i.e., qualified. In other words, the whole matter is taken out of the clinician's hands. The ethical principle is no longer something that derives from good practice; it is imposed by the State as a universal demand on the profession.

The logical consequences of seeing the situation in this way are twofold. First, the aims of treatment, which can be identified in the present, are subordinated to a kind of generalized legal and political speculation about what might one day be in the greater interests of society; that is, confidentiality is politicized. Second, a solemn professional duty is gradually transformed into an unrealistic pretense of secrecy, i.e., confidentiality is bureaucratized. If things as ordinary as collegial consultations or supervision are required as part of treatment or if the family needs to be told that the patient is very psychotic and must have his medications supervised, absolute confidentiality will require that the patient first be asked permission, which he may not grant. As every practitioner knows, when vital information is withheld and professional communication is blocked for this kind of bureaucratic reason (e.g., the possibility of a lawsuit if the patient's "right" is not respected), entirely avoidable tragedies occur. When this kind of thing happens, what we are in fact witnessing is a bioethically institutionalized form of substandard practice. A kind of looking-glass culture evolves, not very different in principle from one in which surgeons would ask their patients for permission to sterilize the instruments before the operation (Furlong, personal communication, 1997).

The illusion that confidentiality is respected and protected because it is derived from a "right" (i.e., included in the rhetoric of universal bioethics) leads, in actual practice, to a cynical and bureaucratic culture of expediency, in which the loss of professional authority based on expertise invites an erosion of the individual practitioner's sense of responsibility. All sorts of new procedures have to be invented to accommodate the new bureaucratic contingency, and the State naturally intervenes with an ever-lengthening list of exceptions to the legalistic construction of confidentiality in order to deal with all the situations potentially requiring its "breach." According to the logic of the reporting laws, for example, the psychotherapist has no ethical or legal choice but to stand by while his patient commits capital crimes (after all, the patient has a "right" to confidentiality)—*unless* (lo and behold!)—the State obliges the analyst to "breach" confidentiality in the greater interests of society. Any reasonable sense of the reality of actual clinical practice tends to get lost in this kind of shuffle, not the least of which is the fact that no competent psychoanalyst in a real emergency would for reasons of confidentiality simply abandon the discretionary power to modify or override the psychoanalytic stance of nonintervention.

The Professional Use of Clinical Material: The Example of Informed Consent

In the bioethical-legalistic construction of the discourse on confidentiality described previously, society's interest (for example, in preventing murder or child abuse) is mistakenly defined as being in fundamental opposition both to the interest of the patient and the interest of the therapeutic process. Psychoanalysts have usually been aware, at some level, that this is a false opposition; that in a democracy the therapeutic interest normally coincides with the best long-term interests of both the patient and society. We do know that analysis does not go very well when the patient is dead, or in jail, or recruiting the analyst as an accomplice in crime. Yet we have gradually allowed ourselves to become ensnared in this binary discourse, using it to our advantage when we can or when the more technical arguments for confidentiality seem politically inexpedient. The problem is that once we have started to ground confidentiality in the social calculus, we become subject to that calculus, and the public will rightly hold us to it.

It is as if we have been working with two versions of confidentiality. The first, which might be called "civic confidentiality," is adopted for various kinds of public consumption. The second, "psychoanalytic

confidentiality," is privately acknowledged in a wise kind of way but never really developed intellectually in our own literature. We have effectively maneuvered ourselves into a kind of doublethink. This is particularly evident in the inclination we have been showing lately to embrace the ethico-bureaucratic device of informed consent, even to argue sometimes for its mandatory use. We say that confidentiality is constitutive to the therapeutic process; but when pressed, we pretend that this is a matter of social pragmatics and consumer trust—or of the civil rights of the patient. Then we proceed to discuss the patient with colleagues and students—worse, to publish articles about him. Critics of psychoanalysis, or of the concept of psychotherapeutic privilege, have quite rightly seized on this opportunity to point out the conflict we are in. Is confidentiality important to us, or is it just a matter of professional convenience? Having tied ourselves to civic confidentiality and not being sure how to explain psychoanalytic confidentiality, we feel morally trapped. So when we want to seek supervision, teach, lecture, or publish, we are tempted to ask the patient to give us permission. In reporting the commitment of this act, some of us positively glow with democratic pride.

The problems with informed consent have already been well argued by others (e.g., Aron, 2000; Gabbard, 2000; Lear, this volume). The main points are the following: asking an analytic patient for consent to "breach" confidentiality for professional reasons such as supervision, teaching, or publication places the analyst in a conflict of interest and the patient in a double bind (though this may be much more difficult for some patients than others). The patient may deeply regret agreeing or not agreeing to grant consent. Moreover, the analyst knows in principle that the patient is not really in a position to answer freely or to predict his later feelings about the decision he takes beforehand. Complicated by the intensity of the transference-countertransference relationship, motivations on both sides in a situation like this are often contradictory and elusive. There is the wish to please the analyst, to be interesting and famous. There is the wish to assert one's independence, to take revenge, to be in control. It is impossible to tell at an early stage what is really going on. The patient knows that the analyst knows this, which makes him wonder what the analyst is really up to. The patient cannot help but ask himself why the analyst has put him in this difficult position. Is it because the analyst is less interested in the analysis than his own advancement? Or is the analyst insecure, guilty, afraid of the patient, or trying to protect himself from the patient?

The last thing that will come to mind is that the analyst is making desperate use of a bureaucratic device in order to wriggle out of an ethical bind that his profession never should have got him into in the first place. The patient may sense that the analyst is in a foolish and awkward position, but he or she will only be able to guess at why and be filled with self-doubt in the process. How long should they analyze these conflicting feelings about the analyst's request before settling on a decision, yes or no? And in the meantime, who should pay for the sessions?

Even if it were possible in this situation to give truly *informed* consent, the informing process might be fatal to analysis, especially in the case of publication (where, paradoxically, the request for consent is actually most justified on ethical grounds). The story here is rather like the one about the operation that was successful, though the patient died. If consent to publish is going to be more than a blanket waiver, then the patient surely has a right to read what the analyst writes in advance of publication. Moreover, the patient, in exercising this right, may legitimately object to certain passages and request changes in others. The analyst will have no choice in this circumstance but to acquiesce, thus compromising his clinical judgment (which the patient will surely note his willingness to do), or else transform the analysis into an editorial bargaining process. The analyst can always decide not to publish, but then he will have to analyze the patient's guilt about this. Or the analyst can apologize to the patient. If consent was what the analyst really wanted from his patient, it might have been better, from both an ethical and clinical point of view, simply to ask in advance for permission to publish as a condition of treatment. Indeed, in comparison to the clinical implications of fully informing the patient once the analytic process is underway, there is a great deal to be said for this procedure, crude as it may be.

Informed consent also has serious implications for the scientific value of our clinical publications, especially if it continues to spread or becomes mandatory. Some authors have argued that submitting clinical reports to the patient for editorial review prior to publication actually enhances the value of the finished product. The patient's vetting of the analytic material not only helps to correct the analyst's blind spots, it liberates the analyst from theoretical prejudices and thus deepens understanding (Stoller, 1988; Gerson, 2000; Pizer, 2006). This may sometimes be true. Indeed, many things might enhance the analyst's understanding of the patient. If this were the issue, we might

well consider interviewing the patient's friends and family as well. The question, however, of the greater or lesser subjective accuracy of any given clinical report is secondary to the problem of introducing a systematic, patient-derived slant into *most or all* clinical reports, producing a massive cumulative effect of distortion.

There is no doubt that individual analysts already have strong preconceptions about the clinical process and that the circumstances of the profession make it more or less inevitable that the evidence produced is poorly controlled for "experimenter bias" (Kandel, 1999). Ordinary clinical reports are constructions, as we have become fond of saying, which means that their scientific value does not lie in the finality of the truth of the individual report but in the gathering image of clinical reality that emerges from the interacting cross section of clinical communication at any given time. This is obviously not a precise procedure, and so it might seem reasonable to conclude, on balance, that granting patients subjective editorial control over clinical material would not have a detrimental influence on the growth of psychoanalytic knowledge.

A brief response to this is the following. First, it is important to remember that all science depends on a commitment to let the exchange of views continue, lest we settle prematurely on a closure of investigation. The inconclusiveness of individual research reports is not a unique property of psychoanalytic case studies; it would also apply to Newtonian physics and any number of competent but finally erroneous scientific conclusions. When we say that it is "the gathering image of clinical reality that emerges from the interacting cross section of clinical communication at any given time," we are not really describing some peculiar aberration unique to the psychoanalytic branch of human knowledge. The distinguishing factor is not the competitive and dialogic form through which certain kinds of psychoanalytic evidence accumulates, is compared, and eventually achieves provisional confirmation. What distinguishes psychoanalysis more radically as a form of investigation from much of the rest of the research community is the contingent fact that the primary subjects of investigation have independent wills and desires. And not just this. The conative activity of the research subject is not, as one would expect, neutralized or factored out in some way but actively solicited and engaged as a condition of the first level of the investigative process, which is the psychoanalytic treatment itself. Any attempt to furnish an accurate picture of the psychoanalytic treatment process must therefore be especially careful not to involve the patient in the process of deciding what should be reported, however useful clinically or therapeutically that might turn out to be in individual, isolated instances.

For this reason, the argument that since the analyst is already biased the patient's bias will naturally serve as a corrective, is patently false. Again, the issue is not the alleged perfection of any individual analyst's clinical perception but the reliability of the overall trend in clinical reporting. Once it becomes established that psychoanalytic case studies have all been vetted by the patient, the current sense that such studies represent on the whole a genuine expression of individual analysts' own well-trained capacity for analytic experience dies. In its place will arise a picture of our clinical work that is censored systematically by the narcissistic and cultural demands of the patient population. In other words, to paraphrase a current political cliché, we will have evolved a body of clinical work that is "intersubjectively correct" but of limited use for the transmission and advancement of psychoanalytic knowledge.

There have been some compelling defenses of informed consent in psychoanalysis, but they usually depend on retheorizations of the analytic relationship that either minimize the role of the unconscious or cancel it out by making it so pervasive that only ad hoc clinical intuition can determine appropriate technique at any given time. Stoller, as we have already seen, argued eloquently that involving the patient in the clinical writing process is therapeutically and scientifically beneficial. I am inclined to believe him, though I place his claim in the context of his personal persuasiveness plus the impression that the patients of whom he speaks seem like befriended research subjects. Much of the intersubjectivist- and relational-theory development enters into the same territory when it comes to informed consent. There is a small but significant literature on the therapeutic benefits of asking for informed consent and on the healing effects of inviting the patient to become a coauthor in what is, after all, the account of a clinical cocreation (e.g., Flax, 2000; Gerson, 2000; Pizer, 2000). One senses that certain analysts can "pull it off," either because they are remarkably open and self-confident individuals or because their therapeutic style includes a capacity to sustain consistently a very high degree of emotionally interactive enmeshment with the patient. As Gabbard (2000) has counseled, it would be a mistake to rule out the device of informed consent a priori. Like confidentiality, the meaning and value of informed consent is to a certain extent context-sensitive. Freebury (this volume) has observed of controversial

niques that though they may raise eyebrows, it would be tyran-
l and antiexperimental to address them as ethical violations, at
t in our present state of knowledge.

The problem posed by arguments for the informed-consent ap-
ach is not so much ethical as pedagogical. This or that analyst
be able to make it work; it may be the best approach to take
such and such a patient; or it may even be the best way for
ain analysts to work all the time. But how do we teach it to
didates as a standard of practice? Seeking informed consent and
simply dealing with the psychic fallout is very much like self-
closure. It may do wonders for a particular patient, it may provide
sorts of beneficial "grist for the mill," but how do we know when
se it and the limit on its use? Do we disclose everything all the
e? How far do we go when we discuss our reasons for wishing to
te about the patient? The usual answer is that it is a matter of
ition, judgment, circumstances, the state of the transference at
time, the personality structure of the patient, the unique dyadic
stellation that has emerged in the treatment. All these consider-
ns are important, but what are the generalizable principles that
be taught here? In itself, intersubjective intuition is indetermi-
e; it provides no background against which the clinical situation
come into view and be assessed, unless we are implicitly presup-
ing something like standard technique as a point of reference.

It is true that the analyst has not just a countertransference but a
nsference to the patient, which cannot possibly be factored out
sciously at all times. It is also true that in principle the analytic
ation is constantly in an uproar of mutual enactment. But we
d to have some teachable method of helping the psychoanalyst
get a handle on these natural human conditions in order to take
antage of them. This is just what Freud tried to provide by setting
he ground rules that help the analyst to distinguish the analytic
ation from the welter of everyday events, giving it some continu-
and stability so that an essential minimum from the infinity of
conscious activity at play in the consulting room can be flagged,
ated, and analyzed. These are the familiar trilogy of neutrality,
nymity, and abstinence. All that has changed since Freud's day is
t we have learned to think of them as approximate "default posi-
ns" rather than as immutable rules. The principles themselves help
establish a consistent and reliable experimental stance that serves
well most of the time. They still set the basic contours of the
lytic frame and are presupposed implicitly by most methods of

working with the unconscious therapeutically, even those that reject the likes of neutrality and anonymity as unnatural, oppressive, or misleading to the patient. So it makes sense to teach that we try to avoid involving the patient directly in the private and personal aspects of our work unless there is very good reason to think otherwise, and our work includes teaching and writing.

The idea that the analytic relationship constitutes an unconscious intersubjective field sometimes gives rise to the suggestion that the patient will already be unconsciously aware of the analyst's intention to widen the circle of interanalytic communication (discuss his case with a supervisor, present his material to a clinical case study group, or write a paper). The thinking here is partly that the analyst has no right to withhold information about something he is doing that may unconsciously affect the patient. It is true that some patients develop an uncanny ability to "read the analyst's mind." But there is a considerable leap from this to the notion that the analyst should preempt the patient's thoughts about the analyst, rather as if the very existence of the analyst as a separate person beyond the patient's control were a toxic iatrogenic irritant to be eliminated for therapeutic reasons.

There is indeed a very common dyadic fantasy, something like what Kurt Vonnegut (1966) called "Das Reich der Zwei," that confidentiality is like a sealed pact of secrecy, the slightest "breach" or "betrayal" of which will deeply wound and harm the patient. The dyadic fantasy has been especially prominent in the listserve discussions of confidentiality I have followed on the Internet. It is often accompanied by a very strong feeling that seems to feed the belief that nothing is worse than running the risk that the patient will later discover a "violation" of confidentiality in print. The intuitive plausibility of this claim seems to come from an understanding of confidentiality as a fusional patient-analyst conspiracy. Indeed, the analyst's sense that publication is fundamentally dishonest, a shameful exploitation and betrayal of the patient, is probably fueled by the unconscious anger, paranoia, and guilt that both patient and analyst have tried to project away from themselves through enactment of the dyadic fantasy or basic assumption group (Caper, 1995).

Many psychotherapists experience feelings of unease about the decision to publish or even merely to present case material. Sometimes they report a sense of relief when the patient's consent is obtained, as if the moral problem is solved. In this case, they seem to be assuming that their uneasiness was caused by the inherent duplicity of the act they were contemplating. This sense of violating the patient

may be related to the fact that the analysand's illusion of (or wish for) an exclusive omnipotent relationship with an utterly devoted analyst is to some degree always a necessary development in the therapeutic process and therefore needs to be protected for a certain period of time. It is part of what used to be called the transference neurosis and would normally be resolved eventually, partly through internalization in the "good-object" mode.

If the internal transformation achieved through the dyadic fantasy relationship turns out, however, to be so easily threatened by subsequent encounters with the analyst's separateness, such as his or her publications, the analysis has probably fallen short of enabling the patient to "contain the container" (Levin, 2002). Informed consent would certainly not have solved this problem. On the contrary, the attempt via informed consent to preempt the shattering of the dyadic illusion only guarantees the destruction of the dyadic fantasy, probably too early from a therapeutic point of view. But there is another possibility: that informed consent will simply be used to install the fantasy on a permanent and henceforth virtually unanalyzable footing through the pretense of coconstruction and coauthorship. All that is accomplished in either of these scenarios is an increased risk of aborting the potential space in which the dyadic fantasy can be experienced virtually as both realizable and not realizable, desirable and undesirable, good and bad. The analysand is instead required to make a choice about it, to *decide*, which is tantamount to taking away or "deconstructing" a child's transitional object before he is ready to give it up; forcing the patient to say yes or no and thus to set his own unconscious destiny, and the analyst's as well.

The analyst's negative feelings about the use of clinical material for professional purposes—the demonization of the act as something that needs to be excused and apologized for—may also be a form of scapegoating. In other words, the analyst may be seeking to rationalize internal conflicts and countertransference problems by displacing them not only onto the patient but onto the profession as well. The displacement onto the profession is essentially moral (e.g., "My wish to publish is not a personal issue; it is inherently unethical, and so I am following standard procedures prescribed by my code of ethics"). The displacement onto the patient is of course much more direct and practical ("Let the patient take the responsibility for what I want to do").

Analysts commonly experience feelings of guilt for having more satisfying and successful lives than certain patients who entertain intense wishes for the exclusive attention of the analyst. The analyst's

psychopathology may well exacerbate such feelings, and the temptation to externalize the conflict can become very strong. When ordinary professional activities and ambitions become the objects of the analyst's paranoia and guilt, these are surely the analyst's personal problems. There may be an intersubjective dimension that needs to be worked through with the patient in one way or another; but generally speaking, the specific contents of the analyst's personal issues need to be handled internally and privately, perhaps through his own analysis. One of the risks of normalizing the informed-consent procedure is to institutionalize a form of acting out and self-disclosure in which the analyst recruits the patient in the externalization of his own conflicts about being a separate person.

The view that subsequent discovery is so harmful to the patient that it must be preempted at all costs is really a form of the "lesser-of-two-evils" argument. It depends upon a rather dubious quantification, namely, that a deliberately imposed risk to the patient and the therapy in every case (informed consent) causes less harm than a possible risk in a few cases (the chance that a patient may one day recognize himself in a clinical report). The "quantity" that tips the balance in this calculus seems to be the exculpation factor. Something felt to be inherently harmful (breaking the pact of secrecy) is confessed and then mitigated by granting the patient a sort of moral "copyright" over the analytic material. The analyst deliberately places himself in a conflict of interest and the patient into a double bind, but this is felt to be the lesser of two evils because the dread possibility of subsequent injury is averted. How is this actually so? The most obvious answer (which is surely at the root of the whole concept of consent) is that the personal legal risks for the professional seem lighter.[3] Moreover, the therapist need no longer feel that he has "betrayed" his patient or that he is "concealing" something from the patient, because he has "come clean"—confessed his sin (the professional use of clinical material) and received absolution from the patient. Everything is resolved politically and democratically because the patient has been given an opportunity to say no.

Patients who do find themselves in their analyst's publications are likely (but by no means always) to be looking pretty hard to find

[3] In fact it seems rather doubtful that this is so. A determined patient could probably still prosecute for breach of confidentiality on the grounds an individual cannot sign away something so basic as a constitutional right to privacy and security of the person.

em, which is an issue for the analysis, not for ethics. One cannot liberately set out to read something by one's analyst without entering at least a faint glimmer of a thought that the analyst might ve been influenced in some way by the patient in what he wrote. ter all, the entire relationship with the analyst tends to be exclusive explicit external influences---other people. It is impossible for the estion of whether one is alive or dead in the analyst's internal orld *not* to be an issue. Frequently, patients will project themselves, aginatively and sometimes literally, into everything they read by eir analyst. (I know I have done this even when I knew the piece as written before my analysis began.) There is also a good chance at what the patient is really looking for is not himself, but precisely e analyst. This leads to consideration of another interesting phemenon: that even when a patient knows that a case report is not out himself it may be shocking and disorienting to read for all the me reasons; it shows the analyst in a very different light than he or e appears in the context of therapy, thinking in very different ways d doing very different kinds of things.

Of course, it would be absurd to try to obtain consent from ery patient who might venture into the sport of the psychoanalytic erature search only to discover that he does not like the way his alyst writes about the analytic process. Again, the problem is clearly e existence of the analyst as a separate person with a separate life, e sense that this reality does not sit comfortably with the dyadic ntasy of an exclusive and fusional relationship. The deeper the nse of betrayal, the more important it is to be dealing with the ue in the analysis itself, but in the form that occurs spontaneously the transference rather than preemptively, as will occur when the ue of publication is proposed by the analyst.

The Professional Community as a Containing Environment

e experience of reviewing the arguments for and against informed nsent in instances of professionally motivated use of clinical mate-l, such as supervision or publication, leaves many readers, I am re, with an uncomfortable sense of the irreconcilability of the prac-ing analyst's ethical conflicts. Articles weighing the pros and cons different approaches to the use of clinical material often conclude a tone of stoical resignation. They lament the fact that for the rposes of scientific advancement, and so forth, we must live with

an unfortunate ethical compromise in which "breaches" and "betrayals" of one of our most fundamental ethical principles will have to be tolerated on a regular basis, for reasons of state, as it were. No wonder our critics have been so scornful. How can a profession base itself on the principle of confidentiality when the very existence of the profession, its teaching and research activities, requires the breaking of that very principle? Is this not an absurd inconsistency, and is not any attempt to get around it through compromise or bureaucratic procedure inherently absurd?

The answer is yes. A profession rooted so fundamentally in flat self-contradiction would be difficult to respect, and any attempt to salvage its reputation by preaching ethical relativism, even in the form of a noble compromise between science and privacy (not to mention securing signatures on pieces of paper) would be worthy of a Kafkaesque satire.

How could such a curious state of affairs have arisen in the first place? This chapter has provided an outline of a possible answer, which will still require a good deal more elaboration. The short version of it is that there is in fact no fundamental inconsistency in the psychoanalytic profession. As argued earlier, the source of the apparent contradiction lies in a misunderstanding or oversimplification, partly condoned by psychoanalysis itself, of the concept of confidentiality. Stated bluntly, anonymous disclosures of clinical material in supervision, teaching, or scientific presentations are not breaches of confidentiality at all. They cannot be considered on the same footing as third-party intrusions on the therapeutic process, mandatory reporting laws, literary self-promotion at the expense of patients, tattle-taling, or idle gossip revealing a patient's identity, the contents of his therapy, or both. Any attempt to equate the professional use of clinical material with unethical breaches of confidentiality or unwarranted intrusions on the privacy of the patient is an exercise in pure political rhetoric, necessarily stripping these incommensurable activities from their defining contexts in order to force a false analogy between them.

The legitimate professional uses of clinical material help to constitute the social context in which psychoanalysis and psychotherapy become possible as organized activities in the first place. They are part of the containing tissue of the confidential relationship, enabling and supporting it in the same way that a social organism is held together by a shared culture. Anonymous professional communication about a patient does not in any way betray the patient or his rights; in fact, it promotes his interests by enriching the scientific and

professional environment that establishes the condition for the psychoanalyst to do consistently good work and to grow as a clinician. The fact that the psychoanalyst does not and cannot work in isolation is often forgotten. The therapist will not function as well or at all if he cannot rely on the good faith of the profession as a whole. The analyst's ability to rely on his supervisors and colleagues to protect sensitive information is part of the necessary background that enables the patient to trust him unconsciously. It also makes the therapist more, not less, trustworthy in the legal and political sense, because it removes the therapist from dangerous isolation. All intraprofessional relationships and forms of communication encompass the therapeutic relationship and are themselves confidential. This does not mean that they are fetishized secrets, the objects of curiosity and speculation. Rather, it means that they preserve the anonymity of the patient at all times; that they maintain normal levels of respect for the patient as a person, regardless of the nature of the information concerning him; that they only occur within a professional context involving the aims of therapy or research; and that they are intended for members of the profession, not produced as exercises in literary self-promotion with the general public in mind.

The importance of respect in all of one's communications with and about the patient is worth underlining and should probably be spelled out more explicitly in our official principles of ethics and guidelines. It is surely an essential component of the culture of confidentiality, of confidentiality as a professional ethos. If respect for the patient cannot always be felt, it still needs to be demonstrated, not only to the patient but also to one's colleagues. Lear in this volume has written of confidentiality as a virtue in the Aristotelian sense of a character trait. Since the method of working in psychoanalysis does not "come naturally," psychoanalytic training includes the instillation of professional attitudes that usually grow roots in the individual analyst's character. Few educational events are as important for one's analytic development and self-confidence as the experience of listening to a good clinician speak respectfully of his patient while protecting his identity. This kind of demonstration *imparts* the professional ethic of confidentiality in a way that no lecture on the concept of patients' rights could ever match. We all learn by participating in a good analyst's narrative of an explosive clinical situation. That analyst's capacity to contain is modeled in his or her way of describing difficulties with a particular patient in a calm, lucid, sensitive, anonymous, and respectful manner. As we think about this way

of being with a patient, we also share and promote a vigorous supporting and containing professional environment for all. We realize that confidentiality is more than an ethical duty; it is an integral part of the way we try to work and of the culture of psychoanalysis.

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